OMB No.: 0915-0253
Exp. Date: 08/31/2004

Ryan White CARE Act Data Report (CARE Act Data Report)

(Cross-Title Data Report)

COVER PAGE

All Ryan White CARE Act grantees should complete this cover page and submit one copy together with all your providers' completed reports. For definition of grantee of record, please refer to the instructions for completing this form.

Name of grantee of record: _____

Grantee ID number: _____

Grantee of record taxpayer ID #: | | | – | | | | | | | |

Grantee contact email address: _____@_____

Total number of CARE Act providers: _____

Name of grantee representative responsible for quality assurance _____

Signature: _____

Check all that apply:

☐ Title I Grantee ☐ Title II Grantee ☐ Title IV Adolescent Initiative

☐ Title III Grantee ☐ Title IV Grantee

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 1. SERVICE PROVIDER INFORMATION

Section 1 (Items 1–23) should be completed by service providers funded through Ryan White CARE Act Titles I, II, III, and IV. For definition of service provider, please refer to the Ryan White CARE Act Data Report instructions.

Part 1.1. Provider and Agency Contact Information

1. Provider name:

_____

2. Provider address:

a. Street: _____

b. City: _____ State: _____

c. ZIP code: __ __ __ __ __ - __ __ __ __

d. Taxpayer ID #: __ __ - __ __ __ __ __ __ __

3. Contact information:

a. Name: _____

b. Title: _____

c. Phone #: (__ __ __) __ __ __ - __ __ __ __

d. Fax #: (__ __ __) __ __ __ - __ __ __ __

e. Email: _____

4. Person completing this form:

a. Name: _____

b. Phone #: (__ __ __) __ __ __ - __ __ __ __

Part 1.2. Reporting and Program Information

5. Calendar year for reporting: (mm/dd/yyyy)

Start date: __ __ / __ __ / __ __ __ __

End date: __ __ / __ __ / __ __ __ __

6. Reporting scope: __ __ *(Select one only.)*

01 = **ALL** Clients receiving a service **ELIGIBLE** for Title I, II, III or IV funding
02 = **ONLY** Clients receiving a Title I, II, III or IV **FUNDED** service

Remember: All grantees and providers must use reporting scope "01" unless they have permission from their HRSA project officer to use "02."

All subsequent items regarding "clients" should be answered relative to the reporting scope you select here.

7. Provider type: *(Select one only.)*

- ☐ Hospital or university-based clinic
- ☐ Publicly funded community health center *(go to #8)*
- ☐ Publicly funded community mental health center
- ☐ Other community-based service organization (CBO)
- ☐ Health department
- ☐ Substance abuse treatment center
- ☐ Solo/group private medical practice
- ☐ Agency reporting for multiple fee-for-service providers
- ☐ PLWHA coalition
- ☐ VA facility
- ☐ Other facility

8. *(If "Publicly funded community health center" in #7,)* **Did you receive funding under Section 330 of Public Health Service Act (funds community health centers, migrant health centers, and health care for the homeless) during this reporting period?**

☐ Yes ☐ No ☐ Don't know/unsure

9. Ownership status: *(Select only one.)*

- ☐ Public/local
- ☐ Public/State
- ☐ Public/Federal
- ☐ Private, nonprofit (not faith-based)
- ☐ Private, for-profit
- ☐ Unincorporated
- ☐ Faith-based organization
- ☐ Other

10. Source of Ryan White CARE Act funding: *(Check all that apply.)*

- ☐ Title I
- ☐ Title II
- ☐ Title III
- ☐ Title IV
- ☐ Title IV Adolescent Initiative

OMB No.: 0915-0253
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Each provider must complete one CADR for all clients served during the reporting period.

11. During this reporting period, did you provide the grantee with support in . . . ? *(Check "yes" or "no" for each service.)*

a. Planning or evaluation	☐ Yes	☐ No
b. Administrative or technical support	☐ Yes	☐ No
c. Fiscal intermediary services	☐ Yes	☐ No
d. Technical assistance	☐ Yes	☐ No
e. Capacity development	☐ Yes	☐ No
f. Quality management	☐ Yes	☐ No

*If any of these services were the **only** services you provided under CARE Act funding, **STOP HERE** and do not complete the remainder of this form. Third party administrators who process fee-for-service reimbursements to providers of eligible services should continue.*

NOTE: Those who provided a direct service other than those listed in #11, continue with #12 and answer items only as they relate to the client services you provided. **ALL OTHERS STOP HERE**.

12. Did you administer an AIDS Drug Assistance Program (ADAP) or local pharmaceutical assistance program that provides HIV/AIDS medication to clients during this reporting period?

☐ Yes *(Continue.)*
☐ No *(Skip to #14.)*

13. *(If "yes" to #12,)* **Type of program administered:**

☐ State ADAP *(If this was the **only** service you provided under CARE Act funding, skip to Section 7.)*
☐ Local pharmaceutical assistance program that provides HIV/AIDS medication to clients *(If this was the **only** service you provided under CARE Act funding, skip to Section 7.)*

14. Did you provide a Health Insurance Program (HIP) during this reporting period?

☐ Yes *(If this was the **only** service you provided under CARE Act funding, skip to Section 8.)*
☐ No

15. Indicate which of the following populations were especially targeted for outreach or services during this reporting period. *(Check box for each group targeted.)*

☐ Migrant or seasonal farm workers
☐ Rural populations other than migrant or seasonal farm workers
☐ Women
☐ Children
☐ Racial/ethnic minorities/communities of color
☐ Homeless
☐ Gay, lesbian, and bisexual youth
☐ Gay, lesbian, and bisexual adults
☐ Incarcerated persons
☐ All adolescents
☐ Runaway or street youth
☐ Injection drug users
☐ Non-injection drug users
☐ Parolees
☐ Other (specify:_____)

16. Which of the following categories describes your agency?*(Check all that apply.)*

☐ An agency in which racial/ethnic minority group members make up greater than 50% of the agency's board members
☐ Racial/ethnic minority group members make up greater than 50% of the agency's professional staff members in HIV direct services
☐ Solo or group private health care practice in which greater than 50% of the clinicians are racial/ethnic minority group members
☐ Other "traditional" provider that has historically served racial/ethnic minority patients/clients but does not meet the criteria above
☐ Other type of agency or facility

17. Total paid staff, in FTEs, funded by any Title of the CARE Act:

_____ Paid staff FTEs

18. Total volunteer staff, in FTEs, dedicated to HIV care:

_____ Volunteer staff FTEs

Each provider must complete one CADR for all clients served during the reporting period.

19. **Amount of Title I funding received during this reporting period** *(rounded to the nearest dollar)*:

$_____

20. **Amount of Title II funding received during this reporting period** *(rounded to the nearest dollar)*:

$_____

21. **Amount of Title III funding received during this reporting period** *(rounded to the nearest dollar)*:

$_____

22. **Amount of Title IV funding received during this reporting period** *(rounded to the nearest dollar)*:

$_____

23. **Amount of Title I, II, III, or IV Ryan White CARE Act funds <u>EXPENDED</u> on oral health care during this reporting period** *(rounded to the nearest dollar)*:

$_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 2. CLIENT INFORMATION

*Service providers from **all Titles** should complete this section. Clients reported in this section should include your HIV-infected and affected population, whether receiving medical care or social support services. Affected clients include those who are HIV negative as well as those with unknown HIV status. An affected client must be linked to a client infected with HIV/AIDS.*

Remember your reporting scope! If you chose Reporting Scope 01 in Item 6, provide information on all clients who received a service eligible for CARE Act funding. If you chose Reporting Scope 02 in Item 6, include only clients who received services funded by Titles I, II, III, and/or IV.

24. Total number of unduplicated clients:

_____ HIV positive
_____ HIV negative (affected)
_____ Unknown/unreported (affected)
_____ Total

25. Total number of new clients:

_____ HIV positive
_____ HIV negative (affected)
_____ Unknown/unreported (affected)
_____ Total

26. Gender:

Number of clients:	*HIV positive*	*HIV affected*
Male		
Female		
Transgender		
Unknown/unreported		
Total		

27. Age (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Less than 2 years		
2–12 years		
13–24 years		
25–44 years		
45–64 years		
65 years or older		
Unknown/unreported		
Total		

28. Hispanic or Latino/a ethnicity:

Number of clients:	*HIV positive*	*HIV affected*
Hispanic or Latino/a		
Non-Hispanic or Non-Latino/a		
Unknown/unreported		
Total		

29. Race:

Number of clients:	*HIV positive*	*HIV affected*
White		
Black or African American		
Asian		
Native Hawaiian or Other Pacific Islander		
American Indian or Alaskan Native		
More than one race		
Unknown/unreported		
Total		

30. Household income (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Equal to or below the Federal poverty line		
101–200% of Federal poverty line		
201–300% of Federal poverty line		
> 300% of Federal poverty line		
Unknown/unreported		
Total		

Each provider must complete one CADR for all clients served during the reporting period.

31. Housing/living arrangements (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Permanently housed	_____	_____
Non-permanently housed	_____	_____
Institution	_____	_____
Other	_____	_____
Unknown/unreported	_____	_____
Total	_____	_____

32. Medical insurance (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Private	_____	_____
Medicare	_____	_____
Medicaid	_____	_____
Other public	_____	_____
No insurance	_____	_____
Other	_____	_____
Unknown/unreported	_____	_____
Total	_____	_____

33. HIV/AIDS status (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
HIV positive, not AIDS	_____	
HIV positive, AIDS status unknown	_____	
CDC-defined AIDS	_____	
HIV negative (affected clients only)		_____
Unknown/unreported		_____
Total	_____	_____

34. Clients' vital/enrollment status (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Active, client new to program	_____	_____
Active, client continuing in program	_____	_____
Deceased	_____	_____
Inactive	_____	_____
Unknown/unreported	_____	_____
Total	_____	_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 3. SERVICE INFORMATION

*Service providers from **all Titles** should complete this section. If you provided a particular service, check the box in column 2 and list the number of clients and the total number of visits for the appropriate service categories. If you provided a particular service but do not know the number of clients or visits during the reporting period, check the unknown box.*

35. Services provided, number of clients served, and total number of visits during this reporting period:

	1 Service Categories	2 Check if service was provided	3a Total # of unduplicated clients		3b Check if # of clients unknown	4a Total # of visits during reporting period		4b Check if # of visits unknown
			HIV+	Affected		HIV+	Affected	
a.	Ambulatory/outpatient medical care							
b.	Mental health services							
c.	Oral health care							
d.	Substance abuse services–outpatient							
e.	Substance abuse services–residential							
f.	Rehabilitation services							
g.	Home health: para-professional care							
h.	Home health: professional care							
i.	Home health: specialized care							
j.	Case management services							
k.	Buddy/companion service							
l.	Child care services							
m.	Child welfare services							
n.	Client advocacy							
o.	Day or respite care for adults							
p.	Developmental assessment/early intervention services							
q.	Early intervention services for Titles I and II							
r.	Emergency financial assistance							
s.	Food bank/home-delivered meals							
t.	Health education/risk reduction							
u.	Housing services							
v.	Legal services							
w.	Nutritional counseling							
x.	Outreach services							
y.	Permanency planning							
z.	Psychosocial support services							
aa.	Referral for health care/supportive services							
ab.	Referrals to clinical research							
ac.	Residential or in-home hospice care							
ad.	Transportation services							
ae.	Treatment adherence counseling							
af.	Other services							

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 4. HIV COUNSELING AND TESTING

Title I, II, III, and IV grantees/service providers who selected the eligible reporting scope (01), and provide HIV-antibody counseling and testing, must report on all items in Section 4. Those who selected the funded reporting scope (02), and provide HIV-antibody counseling and testing, but do not use CARE Act funds, should respond to #36 and #37, then skip to Section 5.

NOTE: Based on Ryan White CARE Act reauthorization, HIV counseling and testing are funded as components of Early Intervention Services for Titles I and II.

*Report only on the number of individuals who received HIV counseling and testing during the reporting period. Until these individuals receive at least one of the services listed in Section 3, they are **NOT** considered clients.*

36. a. Was HIV counseling and testing provided as part of your program during this reporting period?

☐ Yes *(Continue.)*
☐ No *(Skip to Section 5.)*

36. b. Indicate the total number of infants tested during this reporting period.

_____ Number of infants tested

37. Were Ryan White CARE Act funds used to support HIV counseling and testing services during this reporting period?

☐ Yes *(Continue.)*

☐ No *(Skip to Section 5, if you selected scope 02 and do not wish to continue with this section.)*

38. How many individuals received HIV pretest counseling during this reporting period?

Number of:

_____ Confidential

_____ Anonymous

(If answer to both categories is "0," skip to #43.)

39. Of the individuals who received HIV pretest counseling *(#38 above)***, how many were tested for HIV antibodies during this reporting period?**

Number of:

_____ Confidential

_____ Anonymous

40. Of the individuals who received pretest counseling and were tested for HIV antibodies *(#39 above)***, how many had a positive test result during this reporting period?**

_____

41. Of the individuals who received HIV pretest counseling and were tested for HIV antibodies *(#39 above)***, how many received HIV posttest counseling during this reporting period, regardless of test results?**

Number of:

_____ Confidential

_____ Anonymous

42. Of the individuals who tested POSITIVE *(#40 above)***, how many did NOT return for HIV posttest counseling during this reporting period?**

_____

43. Did your program offer partner notification services during this reporting period?

☐ Yes *(Continue.)*

☐ No *(Skip to Section 5.)*

44. *(If "yes" in #43,)* **How many at-risk partners were notified during this reporting period?**

_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 5. MEDICAL INFORMATION

*This section should be completed by **all medical service providers** funded through Ryan White CARE Act Titles I, II, III, or IV or by authorized personnel who have access to this information for CLIENTS WHO ARE HIV POSITIVE ONLY.*

45. Total number of unduplicated clients reporting on in this section by gender:

_____ Male
_____ Female
_____ Transgender
_____ Unknown/unreported
_____ Total

46. Total number of clients who are HIV positive with each of the listed risk factors for HIV infection:

Persons with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for persons with a history of both homosexual/bisexual contact and injection drug use. They are counted in a separate category, i.e., MSM and IDU.

_____ Men who have sex with men (MSM)
_____ Injection drug user (IDU)
_____ Men who have sex with men and injection drug user (MSM and IDU)
_____ Hemophilia/coagulation disorder
_____ Heterosexual contact
_____ Receipt of transfusion of blood, blood components, or tissue
_____ Mother with/at risk for HIV infection (perinatal transmission)
_____ Other
_____ Undetermined/unknown/risk not reported or identified
_____ Total

47. Number of clients who received each of the following at any time during this reporting period:

_____ TB skin test (PPD Mantoux)
_____ Treatment due to a positive TB skin test
_____ Screening/testing for syphilis
_____ Treatment for syphilis
_____ Screening/testing for any treatable sexually transmitted infection (STI) other than syphilis and HIV
_____ Treatment for an STI (other than syphilis and HIV)
_____ Screening/testing for hepatitis C
_____ Treatment for hepatitis C

48. Number of clients diagnosed with each AIDS-defining condition during this reporting period:

_____ Pneumocystis carinii pneumonia (PCP)
_____ Mycobacterium avium complex (MAC)
_____ Mycobacterium tuberculosis
_____ Cytomegalovirus disease
_____ Toxoplasmosis
_____ Cervical cancer
_____ Other AIDS-defining condition

49. Number of clients on the following antiretroviral therapies at the end of the reporting period:

_____ None
_____ HAART
_____ Salvage
_____ Other (mono or dual therapy)
_____ Unknown/unreported
_____ Total

50. Number of clients who received a pelvic exam and Pap smear during this reporting period:

_____

51. Number of clients who are HIV positive who were pregnant during this reporting period:

_____

52. Of the number of pregnant clients who are HIV positive *(#51 above)*, number entering care in the:

_____ First trimester
_____ Second trimester
_____ Third trimester
_____ At time of delivery
_____ Total

53. Number of pregnant clients *(#51 above)* who received antiretroviral medications to prevent the transmission of HIV to their children:

_____

54. Number of children delivered to clients who are HIV positive *(#51 above)*:

_____

55. Of the number of children delivered *(#54 above)*, number HIV positive:

_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 6. DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV

Part 6.1 should be completed by Title III grantees/service providers. Part 6.2 should be completed by Title IV grantees/service providers. Title I and II grantees should skip to Section 7.

Part 6.1. Title III Information

*Part 6.1 should be completed by Title III grantees/service providers only. When reporting on **PATIENTS** in this section, only report on **PATIENTS WHO ARE HIV POSITIVE who received PRIMARY HEALTH CARE SERVICES**.*

56. Number of patients who are HIV positive during this reporting period by Hispanic or Latino/a ethnicity, gender, and age.

Ethnicity/Origin	Gender	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Hispanic or Latino/a	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Non-Hispanic or Non-Latino/a	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

57. Number of patients who are HIV positive during this reporting period by race, gender, and age. *(All Hispanic or Latino/a patients reported in Table 56 should also be included in this table.)*

Race	Gender	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
White	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Black or African American	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Asian	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Native Hawaiian or Other Pacific Islander	Male								
	Female								
	Transgender								
	Unknown/ unreported								
American Indian or Alaskan Native	Male								
	Female								
	Transgender								
	Unknown/ unreported								
More than one race	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

58. Number of patients who are HIV positive during this reporting period by HIV exposure category, gender, and race.

HIV Exposure Category	Gender	White	Black or African American	Asian	Native Hawaiian or other Pacific Islander	American Indian/ Alaskan Native	More than one race	Race unknown	Total
Men who have sex with men (MSM)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Injection drug user (IDU)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
MSM and IDU	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Hemophilia/ coagulation disorder	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Heterosexual contact	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Receipt of transfusion of blood, blood components, or tissue	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Mother with/at risk for HIV infection (perinatal transmission)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Other	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

59. Number of patients who are HIV positive during this reporting period by HIV exposure category, gender, and age.

HIV Exposure Category	Gender	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Men who have sex with men (MSM)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Injection drug user (IDU)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
MSM and IDU	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Hemophilia/ coagulation disorder	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Heterosexual contact	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Receipt of transfusion of blood, blood components, or tissue	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Mother with/at risk for HIV infection (perinatal transmission)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Other	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

60. Cost and revenue of primary care* and other programs† during this reporting period:

a. Total cost of providing service:

$_____ Primary care

$_____ Other program

b. Title III grant funds **expended:**

$_____ Primary care (excluding pharmaceuticals)

$_____ Other program

$_____ Pharmaceuticals

c. Direct collections from patients:

$_____ Primary care

$_____ Other program

d. Reimbursements received from third party payer:

$_____ Primary care

$_____ Other program

e. All other sources of income:

$_____ Primary care

$_____ Other program

*Includes medical, subspecialty care, dental, nutrition, mental health and substance abuse treatment, and pharmacy services; radiology, laboratory and other tests for diagnosis and treatment planning; HIV counseling and testing; and the cost of making and tracking referrals for medical care.

†Includes case management and eligibility assistance, outreach, social work, prevention education and harm reduction. If you are providing a Title III-eligible service, include it, even if it is not being funded under your grant.

61. Were services available through your Early Intervention Services (EIS) program provided at more than one site during this reporting period?

☐ Yes *(Continue.)*

☐ No *(Skip to #63.)*

62. *(If "yes" to #61,)* **Number of sites at which EIS services were provided during this reporting period:**

_____

63. Please indicate which of the following primary care services were made available to your clients who are HIV positive during this reporting period. *(Choose "within the EIS program" if you provided the service directly and/or through a contractual relationship with another service provider. Choose "through referral" if it was offered by another agency with which you had no remunerative relationship but to whom you referred. Choose "No" if the service was not available.)*

	Yes, within the EIS program ▼	Yes, through referral ▼	No ▼
a. Ambulatory/outpatient medical care	☐		
b. Dermatology	☐	☐	☐
c. Dispensing of pharmaceuticals	☐	☐	☐
d. Gastroenterology	☐	☐	☐
e. Mental health services	☐	☐	☐
f. Neurology	☐	☐	☐
g. Nutritional counseling	☐	☐	☐
h. Obstetrics/gynecology	☐	☐	☐
i. Optometry/ophthalmology	☐	☐	☐
j. Oral health care	☐	☐	☐
k. Rehabilitation services	☐	☐	☐
l. Substance abuse services	☐	☐	☐
m. Other services	☐	☐	☐
n. Not applicable	☐		

64. How many unduplicated patients who are HIV positive were referred outside the EIS program for any health service that was not available within the EIS program during this reporting period?

_____

Each provider must complete one CADR for all clients served during the reporting period.

Part 6.2. Title IV Information

Part 6.2 should be completed by Title IV grantees/service providers only. The clients who are HIV negative/unknown (affected) who are reported in this section must be a family member or partner of a client who is HIV positive. Report only on those clients who received Title IV services.

65. Number of clients during this reporting period by gender, HIV status, and age.

Gender	HIV Status	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Male	HIV positive								
	HIV-/unknown								
Female	HIV positive								
	HIV-/unknown								
Transgender	HIV positive								
	HIV-/unknown								
Unknown/ unreported	HIV positive								
	HIV-/unknown								
Total	HIV positive								
	HIV-/unknown								

66. Number of clients during this reporting period by Hispanic or Latino/a ethnicity, HIV status, and age.

Ethnicity/Origin	HIV Status	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Hispanic or Latino/a	HIV positive								
	HIV-/unknown								
Non-Hispanic or Non-Latino/a	HIV positive								
	HIV-/unknown								
Unknown/ unreported	HIV positive								
	HIV-/unknown								
Total	HIV positive								
	HIV-/unknown								

Each provider must complete one CADR for all clients served during the reporting period.

67. Number of clients during this reporting period by race, HIV status, and age. *(All Hispanic and Latino/a clients reported in Table 66 should also be included in this table.)*

Race	HIV Status	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
White	HIV positive								
	HIV-/unknown								
Black or African American	HIV positive								
	HIV-/unknown								
Asian	HIV positive								
	HIV-/unknown								
Native Hawaiian or Other Pacific Islander	HIV positive								
	HIV-/unknown								
American Indian or Alaskan Native	HIV positive								
	HIV-/unknown								
More than one race	HIV positive								
	HIV-/unknown								
Unknown/ unreported	HIV positive								
	HIV-/unknown								
Total	HIV positive								
	HIV-/unknown								

68. Number of clients who are <u>HIV POSITIVE</u> during this reporting period by HIV exposure category and age.

HIV Exposure Category	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Men who have sex with men (MSM)								
Injection drug user (IDU)								
MSM and IDU								
Hemophilia/coagulation disorder								
Heterosexual contact								
Receipt of transfusion of blood, blood components, or tissue								
Mother with/at risk for HIV infection (perinatal transmission)								
Other								
Undetermined/unknown								
Total								

STOP HERE IF YOU DO NOT PROVIDE ADAP OR HIP TO YOUR CLIENTS!

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 7. APA INFORMATION

This section should be completed by all Ryan White CARE Act Title II grantees who administer their State AIDS Drug Assistance Program or Title I/II-funded grantees who administer a local AIDS pharmaceutical assistance (APA) program. This section should **not** *be completed by CARE Act programs that provide* ***funding*** *to pharmaceutical programs but do not provide pharmacy services or administer pharmacy programs.*

A State ADAP program is an AIDS Drug Assistance Program administered by a State or Territory.

1. Medical eligibility: *(Check all that apply.)*

- ☐ CD4 lymphocyte count
- ☐ HIV positive
- ☐ Other

2. Average application processing period:

- ☐ Less than 5 days
- ☐ 5–10 days
- ☐ 11–30 days
- ☐ 31–60 days
- ☐ More than 60 days

3. Frequency of recertification:

- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually
- ☐ Other
- ☐ Not applicable

4. Total number of *UNDUPLICATED* clients in this reporting period:

_____

5. Total number of *NEW* clients served in this reporting period:

_____

6. Gender:

Number of clients:

_____ Male
_____ Female
_____ Transgender
_____ Unknown/unreported
_____ Total

7. Age (at the end of reporting period):

Number of clients:

_____ Less than 2 years
_____ 2–12 years
_____ 13–24 years
_____ 25–44 years
_____ 45–64 years
_____ 65 years or older
_____ Unknown/unreported
_____ Total

8. Hispanic or Latino/a ethnicity:

Number of clients**:**

_____ Hispanic or Latino/a ethnicity
_____ Non-Hispanic or non-Latino/a ethnicity
_____ Unknown/unreported
_____ Total

9. Race:

Number of clients:

_____ White
_____ Black or African American
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ American Indian or Alaskan Native
_____ More than one race
_____ Unknown/unreported
_____ Total

Each provider must complete one CADR for all clients served during the reporting period.

Agency Fiscal Information

10. Enter FUNDING received from following CARE Act sources:

Funding source	Funding received
Total Title I funds	$ _ _, _ _ _, _ _ _
EMA #1 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #2 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #3 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #4 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #5 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #6 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #7 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #8 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #9 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #10 __ __ __ __	$ _ _, _ _ _, _ _ _
Total Title II funds	$ _ _, _ _ _, _ _ _
Other CARE Act funding	$ _ _, _ _ _, _ _ _

11. Enter total FUNDING received from other sources:

Funding source	Funding received
Federal Section 330	$ _ _, _ _ _, _ _ _
Other Federal funding	$ _ _, _ _ _, _ _ _
State/local	$ _ _, _ _ _, _ _ _
Client payments	$ _ _, _ _ _, _ _ _
Manufacturer rebates	$ _ _, _ _ _, _ _ _
All other sources not included above	$ _ _, _ _ _, _ _ _

12. Annual expenditures for health insurance services within ADAP or APA:

Source	Total cost	Undup-licated clients	Total client-months
a. High-risk insurance pool			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
b. Medicare supplement			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
c. Other health insurance			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
TOTAL HEALTH INSURANCE EXPENDITURES			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _

13. Annual expenditures for services under the Flexibility Policy:

_____ Adherence
_____ Access
_____ Monitoring
_____ Total flexibility expenditures

14. Total expenditures: *(Include health insurance, flexibility, PLUS dispensing and other administrative costs.)*

$ __ __ __, __ __ __, __ __ __

Each provider must complete one CADR for all clients served during the reporting period.

15. **For each medication prescribed, enter the HRSA drug code, unduplicated number of clients who received that drug, and the total cost.**

HRSA drug code	Unduplicated # of clients receiving drug	Total cost
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _
_ _ _ _ _ _	_ _ _, _ _ _	$_ _ _, _ _ _, _ _ _

STOP HERE UNLESS YOU ARE A SERVICE PROVIDER ADMINISTERING HIP.

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 8. HEALTH INSURANCE PROGRAM (HIP) INFORMATION

This section should be completed by the state agency and other entities that used CARE Act funds to pay for or supplement a client's health insurance. This section should **not** *be completed by CARE Act grantees providing funding to another HIP program, or by service providers who ONLY PROVIDE VOUCHERS FOR HEALTH INSURANCE.*

A Health Insurance Program is a program authorized and primarily funded under Title I or Title II of the CARE Act that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.

1. Total number of *UNDUPLICATED* clients in this reporting period:

_____

2. Total number of *NEW* clients served in this reporting period:

_____

3. Gender:

Number of clients:

_____ Males
_____ Females
_____ Transgender
_____ Unknown/unreported
_____ Total

4. Age (at the end of reporting period):

Number of clients:

_____ Less than 2 years
_____ 2–12 years
_____ 13–24 years
_____ 25–44 years
_____ 45–64 years
_____ 65 years or older
_____ Unknown/unreported
_____ Total

5. Hispanic or Latino/a ethnicity:

Number of clients**:**

_____ Hispanic or Latino/a ethnicity
_____ Non-Hispanic or non-Latino/a ethnicity
_____ Unknown/unreported
_____ Total

6. Race:

Number of clients:

_____ White
_____ Black or African American
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ American Indian or Alaskan Native
_____ More than one race
_____ Unknown/unreported
_____ Total

7. Annual expenditures for HIP:

Source	Total cost	Undup-licated clients	Total client-months
a. High-risk insurance pool			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
b. Medicare supplement			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
c. Other health insurance			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
TOTAL HEALTH INSURANCE EXPENDITURES			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _

Each provider must complete one CADR for all clients served during the reporting period.

8. Total expenditures: *(Include "Total Health Insurance Expenditures" above plus any other administrative costs.)*

$__ __ , __ __ __, __ __ __

9. Annual funding for HIP by CARE Act funds:

Funding source	Funding received
Total Title I funds	$ _ _, _ _ _, _ _ _
EMA #1 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #2 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #3 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #4 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #5 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #6 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #7 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #8 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #9 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #10 __ __ __ __	$ _ _, _ _ _, _ _ _
Total Title II funds	$ _ _, _ _ _, _ _ _
ADAP funds	$ _ _, _ _ _, _ _ _
Other CARE Act funding	$ _ _, _ _ _, _ _ _

10. Annual funding for HIP by other sources:

Funding source	Funding received
Federal Section 330	$ _ _, _ _ _, _ _ _
Other Federal funding	$ _ _, _ _ _, _ _ _
State/Local	$ _ _, _ _ _, _ _ _
Client payments	$ _ _, _ _ _, _ _ _
All other sources not included above	$ _ _, _ _ _, _ _ _

END OF REPORT